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ABSTRACT

A parent training program used at the Humboldt State University Speech and Hearing Center helps parents of language impaired children learn to incorporate language facilitation techniques into their daily interaction with their children. The approach used is the INREAL model which was designed to improve the language and related learning skills of 3- to 5-year-old children in a naturalistic, non-stigmatizing way. Techniques used include mirroring, self-talk, parallel talk, verbal monitoring and reflecting, expansion, and modeling. Training features videotapes and audiotapes and clinician-parent feedback. The training program sequence for assessment and planning is outlined and eight phases of the training program procedures are briefly described. (CL)

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A PARENT TRAINING PROGRAM FOR LANGUAGE IMPAIRED CHILDREN

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ASLHA Annual Convention: Washington, D.C.
November 25, 1985

ABSTRACT

The purpose of this paper is to describe a parent training program currently in use at the Humboldt State University Speech and Hearing Center. By following this approach parents of language impaired children learn to incorporate language facilitation techniques into their daily interactions with their children. The literature that supports the rationale and design for this model will be reviewed followed by a detailed description of the intervention program. This includes an outline of its sequence and a step-by-step delineation of the training phases. Hand-outs will supplement the discussion and adaptations of the program for parent groups, for siblings of language impaired children, and for student training will be mentioned.

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Language learning children are normally immersed in an environment specially suited to stimulate their acquisition of communicative skills. By speaking in a redundant, repetitive, and slower manner, the caregiver facilitates the acquisition of formal linguistic skills in a style which is within the cognitive realm of the child. It also appears that the acquisition of some social aspects of language (e.g., turn-taking and cohesiveness of topic) are facilitated during adult-child interactions.

In contrast, any impairment (disorder or delay) of a child's communication system often has an effect on how the child is perceived and responded to by his family. More specifically parents of language impaired children may develop patterns of interaction that are not conducive to language development. Because of that, Hubbell(1981) proposed that our goal in working with parents is not to teach the parent to teach the child, but to "establish transactional patterns between child and parents that maximize the opportunities for language growth in the child" (p.275). According to Hubbell this entails keeping the focus on behavior change rather than on emotions.

Our training program was therefore developed out of a need to systematically teach parents of language impaired children the language facilitation techniques used with their children in our Speech and Hearing Center. The approach that we use with these children is based on the INREAL Intervention Program (Weiss, 1980). The INREAL model is built upon the innatist theory of language learning; it was designed to improve the language and related learning skills of 3 to 5 year old language impaired children with a naturalistic, non-stigmatizing method. More specifically, when using this approach the therapist does not

manipulate the situation in order to elicit responses from the child, but enters the situation by reacting to the child's freely chosen communicative and linguistic repertoire. The techniques used include: mirrorring, self-talk, parallel talk, verbal monitoring and reflecting, expansion, and modeling.

Our approach is designed for use with one or both parents or other primary caretakers of children aged 3 to 5 whose language is impaired. The duration of the program depends on the time needed by the parent to reach the long-term objectives and to generalize newly learned skills to the home environment. The structure of the program is described in the appendix. The skills to be learned by the parents are presented in a series of logically ordered steps. This enables them to enjoy a high rate of success, allows for increased familiarity with the procedures, and facilitates generalization. Parents proceed from one training phase to the next by demonstrating usage of the learned technique according to a pre-set criterion.

Hand-outs are distributed throughout the course of the training; these are written in simple language and are first read by the clinician who can then answer questions. All that is expected of the parents is within their repertoire; videotapes are used in the clinic to facilitate learning of concepts taught and to provide visual reinforcement. In addition parents use audio-tapes at home to monitor themselves. Finally, the clinician routinely fills out score sheets and record forms for the dual purpose of record keeping and providing feedback to the parents.

This program should be administered by a certified or licensed speech/language pathologist; however a student can easily be trained to administer it under supervision. Certain steps of the program can be administered to a small group of parents; other steps need to be modified for group use. The program can also be adapted to train older siblings of language impaired children.

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APPENDIX

TRAINING PROGRAM STRUCTURE
(hand-out distributed at convention)

I. TRAINING PROGRAM SEQUENCE

A. Assessment

1. Child

a. Tests: - language production and comprehension
- phonology, semantics, morphology, syntax, pragmatics

b. Language sample analysis - MLU, TTR, DSS, etc.

2. Parent with child : Adult-Child Interaction Assessment (Lowe, 1980)

a. MLU - child and parent

b. Turn taking - $\frac{\text{number of parent utterances}}{\text{number of child utterances}}$

c. Parent communication strategies
- statements (declaratives)
- commands (imperatives)
- questions (interrogatives)
- social fillers

B. Planning

1. Identification of goals for child

2. Identification of goals for parents and of techniques to train

a. Is the parent MLU too long? i.e longer than child's by 2 morphemes?
GOAL - decrease MLU
TECHNIQUE - Mirroring, Reflecting I, Reflecting II

b. Is the ratio of parent to child utterances = or> 2?
GOAL - decrease number of parent utterances
- establish turn taking ratio of 1 to 1.5
TECHNIQUE - Mirroring, Reflecting I

c. Is the ratio of parent to child utterances = or < .5?
GOAL - increase number of parent utterances
establish turn taking ratio of 1
TECHNIQUE - Mirroring, Reflecting I, Reflecting II, Expansion

d. Are the majority of parent utterances questions and/or commands?
GOAL - decrease (eliminate) questions and/or commands
- establish, increase use of statements and social fillers
TECHNIQUES - Mirroring, Self Talk, Paralell Talk, Reflecting I,
Reflecting II, Expansion

II. TRAINING PROGRAM PROCEDURES

A. Phase one: parent learns about the program
   1. The program rationale is explained, questions are answered

   2. Parent reads a hand-out
      a. the technique to learn is described
      b. examples appropriate to child and parent are provided
      c. parents identify 5 instances of technique use from the hand-out

   3. Questions are answered

   4. Criterion for progressing to phase 2: parent provides 3 examples of possible technique use at home

B. Phase two: Parent learns to identify the technique
   1. Parent observes demonstration of technique on video-tape (5 minutes)

   2. Parent observes another video tape and signals clinician when technique is used. Criterion: 10 consecutive correct identifications

   3. Parent observes clinician with child (5 minutes)

   4. Parent signals clinician when technique is used. Criterion: as above.

C. Phase three: Parent learns to use the technique
   1. Parent plays with child for 5 minutes while video-taped

   2. Parent observes video and identifies uses and misuses of technique

   3. Repeat procedure until parent identifies all correct and incorrect use of technique for three different 5 minute episodes.

D. Phase four: Parent uses the technique in the clinic
   1. Parent plays with child for 5 minutes, uses the technique 5 times

   2. Repeat procedure until parent can play with child for 10 minutes and use the technique at least 20 times, for a minimum of 3 sessions.

E. Phase five: Parent uses the technique at home
   1. Parent uses technique daily for one 10 minute segment of interaction with child for 3 days. Parent audio tapes these segments

   2. Parent identifies uses and misuses of techniques in a diary.

   3. Audio tape and diary are reviewed with clinician.
      a. Continue with home practice and increase number of daily interactions
      or
      b. Provide additional in-clinic training

   4. Criterion: parent uses technique daily for one week, 20 times in 10 minute segments of interaction with child.

F. Phase six: Probe/assessment
   1. Child language

   2. Parent-child interaction

G. Phase seven: Selection of next training technique
   1. Phases 1 through 5 as above except that two techniques have to be learned, identified and used

   2. Phases 6 and 7: as above

H. Phase eight: Gradual termination of training program
   1. Bi-weekly probes for two months

   2. Monthly probes for three months